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IN THE
Supreme Court of the United States
OCTOBER TERM, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS AND BLUE SHIELD PLANS and EMPIRE BLUE CROSS AND BLUE SHIELD,
Petitioners,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

MARIO M. CUOMO, *et al.*,
Petitioners,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK STATE,
Petitioner,
v.
THE TRAVELERS INSURANCE COMPANY, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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REPLY BRIEF FOR PETITIONERS MARIO M. CUOMO, *ET AL.*

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REPLY BRIEF FOR PETITIONERS MARIO M. CUOMO, *ET AL.*

This brief is submitted by petitioners Mario M. Cuomo, *et al.* ("New York") in reply to the briefs of the respondents, The Travelers Insurance Company, *et al.* ("commercials"), the New York State Conference of Health Maintenance Organizations ("HMOs"), and their various

amici. New York's reply brief will address only the issue of whether the State's health care assessments "relate to" ERISA plans within § 514(a) of ERISA, 29 U.S.C. § 1144(a). Having abandoned their argument made before the courts below that the health care assessments are preempted solely because they raise ERISA plan costs, respondents now argue that the assessments are preempted because their indirect economic effect on plan costs purposefully interferes with a fundamental decision of ERISA plans, the choice of health care coverage. (Trav. Br. 16; HMO Br. 19). Even assuming that a state law would be preempted by ERISA on that basis, this argument finds no support in the record below or in the factual findings of the district court.[1]

Moreover, while respondents purport to limit their challenge to what they characterize as "discriminatory" assessments, and imply that uniform regulation does not "relate to" plans,[2] respondents' theory permits no such

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[1] The district court found that the assessments lead indirectly to an increase in plan costs and that this effect, although indeterminate, was substantial. (A. 70-73). The court found that, in response to the cost increase, "plans may reduce the level of benefits or services offered rather than increase costs to participants—a burden on plan administration which ERISA was designed to avoid." (A. 74). The district court did not find that this economic effect influenced or interfered with the decisions of plans concerning the choice of health care coverage. Nor could the district court have made such a finding based upon the only evidence submitted by the commercials and the HMOs showing that increased costs would be passed along to plans in premiums or subscriber fees (A. 71), and the evidence submitted by the State and the intervenors as to the different purposes of each assessment. *See, infra*, p. 6 n.7.

[2] The *amici* argue, however, that uniform hospital rate regulation, for example, New York's bad debt and charity care allowance, which is part of every patient's hospital bill (*see*, N.Y. Pub. Health Law § 2807-c(14)), is preempted because it increases the cost of hospital care and because variations from state to state interfere with uniform plan design. (*See, e.g.*, Brief of National Coordinating Committee of Multiemployer Plans ("NCCMP") at 24-25; Brief of International Foundation of Employee Benefit Plans ("IFEBP") at 12-13). The HMOs expand this "discrimination"

distinction and would compel preemption of virtually all state attempts to regulate health care and control health care costs. State regulation, whether applied uniformly or not, may influence some ERISA plan decisions concerning their structure or administration, including decisions on whether to provide benefits, which benefits to provide, upon what terms to provide benefits, and how to provide benefits.

Under respondents' theory, state laws whose only impact on plans is the indirect economic one of increasing the cost of goods and services purchased by plans are preempted by ERISA. This argument sweeps far too broadly. New York's position is that states may, without facing preemption by ERISA, impose legal obligations upon entities with which ERISA plans do business, *e.g.*, hospitals, day care centers, insurance companies, and HMOs, even if the state regulation may influence plan decisions, so long as it does not dictate or restrict ERISA plans' structure or administration.

ARGUMENT

I. THE HEALTH CARE ASSESSMENTS AFFECT ERISA PLANS ALONG WITH OTHER PARTICIPANTS IN THE HEALTH CARE MARKETPLACE.

While respondents cannot deny that the health care assessments are not directed at, and do not affect solely, ERISA plans, they portray the assessments in that manner. (Trav. Br. 13, 16-19; HMO Br. 20-24).[3] Contrary

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theory, arguing that any regulation imposed upon HMOs, but not upon Blue Cross or commercial insurers, is discriminatory and, therefore, is preempted if it has an adverse economic impact upon HMO rates (HMO Br. 19).

[3] Although they point to the roughly 88% of non-elderly Americans with private health insurance who receive their health care coverage through their employers (JA 35), that does not mean that 88% of the impact of the health care assessments is on ERISA plans. ERISA plans do not pay 88% of hospital bills because not all health care plans are covered by ERISA. A large number of hospital bills are also paid by public programs, such as Medicare and Medicaid. In addition, a large number of elderly persons,

to that portrayal, without regard to their purpose or effect, the health care assessments take in all participants in the health care marketplace, specifically consumers of hospital services or HMOs (in the case of the 9% assessment), not just ERISA plans. This distinction is significant because laws that refer to, apply solely to, or are dependent upon, ERISA plans may be preempted for that reason alone.[4] *District of Columbia v. Greater Washington Board of Trade*, —— U.S. ——, 113 S.Ct. 580 (1992). Thus, New York does not argue, as the commercials claim (Trav. Br. 13), that all laws of general applicability are exempt from ERISA preemption or subject to a different standard.[5]

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excluded from the 88% figure, have Medicare supplemental health care coverage through private insurance. The record shows that, in 1985, one million of them received that coverage through Blue Cross (Anderman Aff., Exh. "B", p. 6). The Hospital Association of New York State ("HANYS") estimates that 25% of hospital bills in New York are paid by ERISA plans (HANYS Br. 24 n.19).

[4] The Second Circuit held that the assessments do not "refer to" plans (JA 52). The commercials again argue that the 13% surcharge refers to ERISA plans, *i.e.*, "self-insured funds," and that this reference is sufficient to preempt the entire statute. (Trav. Br. 27-28). As a factual matter, however, a reference to a self-insured fund is not a reference to an ERISA plan or even to an employee benefit plan since not all self-insured funds are employee benefit plans. For example, professional or trade associations, such as the American Bar Association, may choose to provide health coverage to their members through self-insurance. Such association insurance programs are not ERISA plans because they are not established by "an employer or by an employee organization." 29 U.S.C. § 1002(1). Nor, obviously, are all employee benefit plans self-insured funds. Moreover, the reference to "self-insured funds" in the Public Health Law is in a listing of all the payors subject to the 13% differential. Thus, the statute would have the same legal effect if it read "all other payors except as provided in N.Y. Pub. Health Law § 2807-c(1)(c)."

[5] The HMO's argument (HMO Br. 32) that the 9% assessment is not a law of general applicability because it is directed at health care ignores the fact that ERISA's concern is with employee benefit plans, not with the benefits that plans may offer. The HMOs'

Nor, contrary to the portrayal of respondents and *amici* (HMO Br. 21; IFEBP Br. 13; NCCMP Br. 5, 17), is this a case in which the state law, although generally applicable, burdens ERISA plans disproportionately, either purposefully or by effect. All payors of hospital bills, including Blue Cross, commercial insurers, HMOs, and self-funded groups include a significant number of ERISA plans as customers. To the extent that any of these entities is burdened or benefitted by the health care assessments, the benefits or burdens may be passed onto ERISA plans among others, such as individual payors and non-ERISA plans. Thus, New York's laws do not, by purpose or effect, burden ERISA plans while benefitting other purchasers of hospital services or other customers of HMOs.

II. STATE LAWS THAT IMPOSE LEGAL OBLIGATIONS UPON ENTITIES WITH WHICH ERISA PLANS DO BUSINESS, BUT WHICH HAVE ONLY AN ECONOMIC IMPACT UPON PLANS AND WHICH DO NOT DICTATE OR RESTRICT PLAN CHOICE, DO NOT "RELATE TO" PLANS.

A. A State Law Which Does Not Dictate Or Restrict Plan Choice, But Which Has An Indirect Economic Impact On Plan Costs, Does Not "Relate To" Plans.

The commercials now argue that the health care assessments have a connection to plans because they have the purpose and effect of influencing ERISA plans' most basic administrative decision—the mechanism by which they provide health care coverage (Trav. Br. 17-18).

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attempt to cast themselves as the "surrogate" of employee benefit plans because they provide health care benefits to plan participants would transform all hospitals, clinics and doctors into employee benefit plans—an absurd result. (HMO Br. 20-24). State regulation of HMOs is simply not direct regulation of employee benefit plans.

Respondents' premise is the same as in the courts below, that the alleged "interference" is accomplished solely through the indirect and economic impact of the assessments on a plan's cost of providing benefits. The assessments impose no legal obligations upon plans and the economic impact on plan costs does not dictate or restrict plan conduct. At most, these laws affect plan choice through the economic regulation of the marketplace in which plans and other consumers of health care operate. Plans, and all other consumers, remain free to choose any method of providing benefits. That choice is not restricted by these assessments which, therefore, do not "relate to" plans.[6]

Moreover, even if the health care assessments had both the purpose and effect of influencing consumers by driving them to Blue Cross (Trav. Br. 16-17), a claim which New York has never conceded, and which cannot be supported on the record or the findings below,[7] the assess-

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[6] Contrary to the claims of the self-insured *amici* (Brief of National Carriers' Conference Committee ("NCCC") at 13; IFEBP Br. 12), this analysis applies equally to self-insured plans. The impact of the 13% differential is indirect because it directs hospitals to bill patients certain amounts, and self-insured plans have no obligation under state law to pay any part of the bill. The effect is still the economic one of possibly increasing plan costs.

[7] The record shows the following as to the various purposes of the assessments. Prior to 1983, when New York State began regulating the hospital rates of all payors and first enacted the differential (originally set at 15%), patients who had commercial insurance or were enrolled in self-insured funds paid from 25% to 40% more for hospital care than Blue Cross subscribers. (JA 149). *See* New York's main brief at 2-3. The purpose of the differential was to "level the playing field" by eliminating cost-shifting. (JA 165-66). The hospital charges paid by commercial insurers and self-insured funds were, thus, reduced to 15% more than Blue Cross paid. While the hospital charges paid by Blue Cross increased, they received a discount of 15% to compensate for the competitive disadvantage they sustained through the higher costs of open enrollment and community rating which only they (and to a lesser extent HMOs) used at the time. (JA 207). Thus, the 13% differential was not designed to influence consumers to choose any particular insurer, but

ments do not "relate to" plans. As urged in New York's main brief, there is a legally significant distinction between laws whose connection to plans is to dictate or restrict behavior, either directly through imposition of legal obligations upon them or indirectly through imposition of legal obligations upon others, and laws that may influence plan choice by affecting, through economic incentives, the marketplace in which plans purchase goods or services. (Main Br. 27). This distinction is not "sterile formalism," as the commercials claim (Trav. Br. 24). If state laws that do not directly or indirectly impose requirements on plans, but which may economically influence plan choices, are held to "relate to" plans, very few state laws would survive a preemption challenge. Virtually all state police power regulation has some economic impact on a marketplace and, therefore, may potentially influence the business choices of entities which operate in that marketplace. However, Congress did not preempt state laws that "might conceivably have an effect on plans," but only laws that "relate to" them.

In addition, the legislative history of ERISA demonstrates that Congress, when it enacted the preemption provision, was concerned with protecting ERISA plans' ability to conduct their multi-state operations uniformly, free from state "regulation," not from state-created influences. In *Shaw v. Delta Air Lines Inc.*, 463 U.S. 85 (1983), the Court quoted the floor statements of the members of Congress who managed ERISA, all of which describe the final conference version of the preemption

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to prevent consumer choice from being artificially influenced by socially useful, but expensive, burdens. The 9% assessment was enacted to raise revenue and to encourage HMOs to enroll Medicaid recipients so that New York could contain its Medicaid costs. (JA 175-76). *See* Main Br. at 6. There is no evidence that the legislature ever considered what impact, if any, this assessment would have on HMO customers. The 11% surcharge was enacted to slow down Blue Cross' loss of all types of good risks from its community rated pools by making commercial insurance more expensive, and to raise revenue. (JA 155). *See* Main Br. at 5. Thus, only the 11% surcharge had the arguable purpose of influencing consumer choice.

provision as preempting laws that, directly or indirectly, *regulate* the operation of ERISA plans. 463 U.S. at 98-99. In *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), the Court again drew upon these statements to demonstrate that ERISA preemption was enacted to prevent states from subjecting plans to different "*regulatory requirements.*" 482 U.S. at 9 (emphasis added). The Court concluded: "Preemption ensures that administrative practices of a benefit plan will be governed by only a single set of *regulations.*" 482 U.S. at 11 (emphasis added).

To regulate is "to fix, establish, or control; to adjust by rule, method or established mode; to direct by rule or restriction; to subject to governing principles or law," Black's Law Dictionary 1451 (6th ed. 1990), in short to dictate or to restrict behavior. While ERISA preemption protects plans' freedom of choice as to their structure or administration from direct or indirect state regulation, it does not guarantee to plans a marketplace free from state-created economic influence. Therefore, laws which do not dictate or restrict plan choice as to structure or administration, either directly through the imposition of legal obligations on plans or indirectly through the imposition of legal obligations upon others, do not "relate to" plans.

For that reason, this case is very different from *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1985), upon which respondents place heavy reliance (Trav. Br. 24; HMO Br. 28-9), where the Court said a mandated benefit law "related to" plans. 471 U.S. at 479.[8] Notwithstanding respondents' claim to the contrary (Trav. Br. 19, HMO Br. 28), the Court showed no concern that the law might influence a plan's decision to become insured. Instead, the Court's concern was that the mandated benefit law indirectly dictated a plan term,

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[8] In *Metropolitan Life*, Massachusetts did not question whether the law "related to" plans. 471 U.S. at 749. Thus, the Court's discussion must be viewed in that context.

the coverage of mental illness, when plans chose commercial insurance. New York submits that, had the Massachusetts mandated benefit law permitted the sale of insurance policies without mental illness coverage, but instead had imposed a 13% surcharge on the cost of those policies (which insurance companies would pass on to those customers in the form of higher premiums), it would not "relate to" plans. Although such a surcharge would have the indirect economic impact of making those policies more expensive to plans, it would not dictate or restrict a plan's choice as to whether to provide mental health coverage.[9] In addition, it would make no difference in this hypothetical situation if Massachusetts' purpose in imposing the surcharge was to influence customers to buy a policy with mental health coverage, or was simply to raise revenue to operate its psychiatric hospitals.

In this case, plans are not required, even as an economic matter, to select any particular payor. Those plans which choose commercial insurance may pay more for hospital care than they would if they chose Blue Cross, but no plan terms are dictated or restricted thereby. Nor are the costs of the 13% differential or the 11% surcharge, which are part of a patient's hospital bill, even indirectly imposed upon plans, including self-insured plans. Even when plans choose what the commercials characterize as a "disfavored" payor (Trav. Br. 17), they still remain free from any state-imposed obligation to pay any particular amount of a hospital bill. If a plan chooses self-insurance over Blue Cross, a participant's hospital bill will amount to 113% of the diagnosis related group rate ("DRG"), N.Y. Pub. Health Law § 2807-c(1)(b), but the plan pays only according to its plan terms. When a

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[9] If a surcharge were so inordinately large, as in the example suggested by the commercials (Trav. Br. 24), that plans could demonstrate that it had the same effect as the mandated benefit law, *i.e.*, requiring insured plans to purchase a particular type of policy, the issue might arguably be different. However, such facts are not present in this case.

plan interprets or structures its plan terms to provide for payment of only the DRG rate, hospitals treat this no differently than any other limit on full payment of the bill by a third-party payor.[10] Thus, plans remain free, under state law, to avoid any adverse economic effect upon hospital costs which their choice of payor may involve.

Contrary to the HMOs' claims (HMO Br. 29), this case is not analogous to *Morales v. Trans World Airlines, Inc.*, —— U.S. ——, 112 S.Ct. 2031 (1992). The Airline Deregulation Act, involved in *Morales*, preempted state laws "relating to rates, routes or services." The purpose of the Act was to remove all regulation of airline rates and to promote " 'maximum reliance on competitive market forces' " which would "best further 'efficiency, innovation, and low prices'." *Morales*, 112 S.Ct. at 2034. In this context, certain states, pursuant to multi-state guidelines, imposed legal obligations upon the airlines' advertisement of discount fares. The airlines demonstrated, and the Court found, that there was a direct connection between their advertising and rates. *Morales*, 112 S.Ct. at 2039. The guidelines, however, did not simply make it more expensive to advertise rates, they severely restricted the airlines' ability to market reduced fares, and sometimes made it impossible to do so. *Morales*, 112 S.Ct. at 2040. Thus, the restriction on airline advertising had a significant and direct impact on fares, restricting the airlines' ability to utilize discount fares. There is no such direct economic restriction of

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[10] For example, at least one commercial insurer, Connecticut General, has made the determination that its plan terms do not permit payment of the 13% differential. (Rachlin Aff., Exh. D). In addition, one of the *amici* representing self-insured plans notes that some health plans would customarily prohibit payment of the 13% differential since that would not be considered a "medically necessary" expense. (Brief of The Self-Insurance Institute of America, Inc. at 13-14). In those cases, hospitals do what is customarily done when a third-party payor does not cover fully a patient's bill for whatever reason, *e.g.*, because of co-payments, deductibles, or the exclusion of certain charges or procedures. They bill the patient for the balance.

plan activities in this case. The *Morales* analogy to this case would be a state law that regulated the *price* of advertising, making it more expensive for airlines to advertise, but not restricting their ability to do so.

In this case, there are no claims, no findings, and no evidence that the indirect economic impact of the health care assessments on plans dictates or restricts plans' ability to structure or administer themselves. The commercials claim that the assessments interfere with a plan's choice of health care provider by imposing costs associated with some, but not all, providers of health care coverage (Trav. Br. 16).[11] The only pertinent evidence in the record is that these assessments may raise some plan costs above what they would be in the absence of the assessments.[12] There is no evidence of the competitive

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[11] The federal government already restricts that choice with respect to HMOs, by requiring all employers with more than 25 employees who provide health care coverage to offer HMOs as an option. 42 U.S.C. § 300e-9. Thus, the HMOs argue only that the 9% assessment interferes with plan structure through the imposition of higher costs which may result in fewer benefits, higher copayments, or both (HMO Br. 25-27).

[12] The record discloses the following. By April 1993, the 9% assessment had translated into an increase of 2.5% to 3.5% in some HMO rates. MetLife had been granted a 7.3% rate increase, effective January 1, 1992, none of which was attributable to the 9% assessment. It was granted a 3.3% rate increase, for the last three months of 1992, to account for the assessment. In January, 1993, MetLife was granted a 21.5% rate increase, 3.3% of which was attributed to the 9% (Rachlin Aff., Exh. A). Oxford Health Plans was granted a variable rate increase of 14.5% to 17.5% (depending upon if the full 9% was assessed) (Rachlin Aff., Exh. B). During that same period, Managed Health Inc., which was not being assessed the 9% because it enrolled its target number of Medicaid recipients, was granted a 12.32% rate increase (Rachlin Aff., Exh. C).

While the commercials claimed that 11% surcharge "put upward pressure" on their rates in 1992 (JA 138), they provided but one lone example of a plan whose rates were increased 7.3%, of which 2.5% was to reflect the surcharge. (JA 299). During the same time period, Empire Blue Cross' rates were increased a total of

impact which the assessments may have on the premiums or subscriber fees of the different types of health care coverage, and, therefore, no evidence of whether they actually influence plan choice.

Moreover, this argument has no merit because it ignores the different regulatory universes in which different providers operate. Blue Cross, HMOs, and the commercial insurers differ in many respects and, thus, are not regulated by the State in identical ways. These differing regulations also affect their costs differently. Self-insured funds are not regulated by the states and, as a result, are able to avoid all costs associated with direct state regulation. Therefore, the costs of different types of health care coverage are affected by many kinds of differing state regulation.

B. An Indirect Economic Impact Which May Influence Plan Choices Does Not "Relate To" Plans Merely Because Those Choices Concern Plan Structure And Administration.

Addressing the argument now made by respondents, the health care assessments do not "relate to" plans merely because the cost of providing benefits may influence choices regarding plan structure or administration. The commercials claim that uniform hospital rate regulation is not challenged in this case, but only "discriminatory" rate regulation because that influences a plan's choice of health coverage provider, its "most basic administrative decision." (Trav. Br. 18-19). The HMOs claim that since choice of

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26.7%, 14.2% in April, 1992, and 12.5% in October, 1992. (Clyne Aff., Exh. I). The commercials also claimed that the 13% differential represented 2% to 5% of premiums paid. (JA 300). However, when enacted, the differential resulted in decreasing hospital care costs, in an amount up to 18%, for commercials and self-insured funds who had faced unregulated cost-shifting (*infra*, p. 6 n.7). If the commercials had passed along any decrease in costs, it would have resulted in a premium reduction of up to 7%. Therefore, given this record, it cannot be concluded that any or all of the assessments, in fact, influence plan choice.

a health care benefit delivery system is a plan's most basic decision, these systems cannot be burdened by the State (HMO Br. 16, 22-24). Respondents support this assertion solely by reference to ERISA's definition of an employee benefit plan as providing enumerated benefits "through the purchase of insurance or otherwise." 29 U.S.C. § 1002(1). (Trav. Br. 17; HMO Br. 23). This reference does not elevate the choice of provider of benefits to a plan's most basic decision; it simply brings those employer programs which provide benefits by purchasing an insurance policy within the ambit of ERISA's coverage.[13] While the method of providing health care coverage is a basic administrative decision, it is no more basic than any other decision which may affect plan structure or administration, for example, whether to provide benefits, which benefits to provide, or upon what terms benefits will be provided (in terms of, *e.g.*, deductibles, co-payments, or excluded procedures).

Moreover, uniform regulation in the health care field may also influence those decisions. As New York previously demonstrated (Main Br. 24-25), to the extent that any uniform regulation of hospitals results in an increase in hospital costs, it may influence plans to eliminate health care benefits, eliminate or reduce inpatient benefits, or raise deductibles or copayments.[14] All regulation in

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[13] The self-insured *amici* make a similar claim tailored to their own interests. They argue that the choice between self-insurance and insurance is a most basic plan decision and, therefore, laws that have an indirect economic effect on this decision "relate to" plans. (NCCC Br. 12; *see also* IFEBP Br. 15). Under this theory, there could not be any state-created disincentives to self-insurance, even if there could be such disincentives as between various insurers.

[14] New York's regulation of residents and interns is a case in point. In 1988, New York implemented the first regulation of the working conditions of interns and residents in the country. These regulations, which limit the hospitals' ability to utilize this relatively inexpensive source of medical personnel, cost hospitals $120 million dollars in the first year of its enactment. (JA 186). These

the marketplace where employee benefit plans operate, which may have an economic impact upon the cost of providing benefits, may affect some plan choices as to structure or benefits. Indeed, the amici make the point that, as a result of increasing health costs, plans are altering their design by adopting larger deductibles and eliminating or reducing certain benefits. (IFEBP Br. 11; NCCMP Br. 15). Any state regulation in any benefit area, be it health care, day care, or prepaid legal services, which may increase the cost of providing benefits may well influence plans to alter some part of plan design. However, if plan choices are not restricted, a law will not otherwise "relate to" plans simply because the indirect economic impact on the cost of providing benefits may influence plan decisions concerning plan structure.

C. State Laws "Relate To" Plans Because Of Their Effect On Plans, Not Because Of Their Legislative Purpose.

The respondents also argue that the health care assessments are preempted because their interference with plan choices is "purposeful." (Trav. Br. 16, 19, 21; HMO Br. 16, 19-24). In *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981), the Court rejected the notion that the purpose of the statute was relevant and, instead, examined its actual impact on plans. 451 U.S. at 524. The subjective intent of the legislature is not a dispositive factor if the law's impact is not, in itself, sufficient to "relate to" plans.[15] Laws which are designed to influence marketplace decisions economically do not "relate to" plans any more than laws which have an unrelated purpose but the same impact. The distinction between the 9% and the

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costs are reflected in higher hospital DRG rates. This increase in the cost of inpatient care may influence plans to cut back or even drop inpatient care benefits.

[15] If the intent of the law is to influence only ERISA plans, then the law will probably refer to or depend upon the existence of employee benefit plans and be preempted on that basis.

11% suffices to make this point. The subjective intent of the legislature, in enacting the 9% assessment, was to influence HMO behavior, not HMO customer behavior (JA 37, 52). The purpose was to encourage HMOs to enroll a target number of Medicaid recipients and also to raise revenue.[16] The 11% surcharge was enacted in an attempt to influence marketplace behavior by stemming the migration of Blue Cross subscribers to the commercials. The impact of the 9% assessment upon the plans that are affected has been a 2.5% to 3.5% rate increase. (JA 1555). This is identical to the impact upon plans that are affected by the 11% differential, which the commercial insurers demonstrated had resulted in a 2.5% rate increase to at least one plan. (JA 299). Thus, the commercials cannot distinguish the Third Circuit's decision in *United Wire, Metal and Machine Health and Welfare Fund v. Morristown Memorial Hospital,* 995 F.2d 1179 (3d Cir.), *cert. denied,* 114 S.Ct. 382 (1993), on the basis that New York seeks to influence plan behavior while New Jersey did not have that purpose. (Trav. Br. 21 n.11). New Jersey's hospital rate-setting statute included surcharges imposed on commercial insurers and self-insured funds and discounts given to plans which had open enrollment. The combined effect of the surcharges and discounts was a 13% differential in favor of Blue Cross. 995 F.2d at 1189-90. The impact on plans and the incentive to switch to Blue Cross coverage is the same under both statutes.

III. THE HEALTH CARE ASSESSMENTS DO NOT INTERFERE WITH MULTI-STATE UNIFORMITY.

Respondents acknowledge that the costs of providing benefits and the costs of the various types of health care

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[16] Although the HMOs rely on "purposeful interference" in the context of the 9% assessment, it is clear from the HMOs' brief (p. 16) and the record that, while the legislature purposefully imposed the 9% on HMOs, there was no legislative purpose to interfere with plan choice. (Main Br. 6).

coverage vary from place to place due to "market factors". (Trav. Br. 23). Indeed, the record in this case demonstrates that the very evil which respondents decry, payor differentials in hospital rates, exists in unregulated markets. (JA 190). Faced with these facts, the respondents can only respond that ERISA bars "state-created" variations in costs. (Trav. Br. at 23). However, this response begs the critical question of whether preemption of these laws furthers the Congressional purpose of enabling multi-state plans to operate uniformly. If the state to state costs of benefits, and the costs of various types of health care coverage, are not uniform even in the absence of preemption, then preemption of these laws would fulfill no Congressional purpose.

Moreover, all state regulation affects multi-state uniformity to the same extent. Like other businesses, ERISA plans do not operate in a marketplace free from state regulation. In their capacity as providers of various types of employee welfare benefits, ERISA plans purchase goods and services, on behalf of themselves or on behalf of their participants, from hospitals, doctors, dentists, pharmacies, medical laboratories, attorneys, banks, securities dealers, commercial insurance companies, not-for-profit health service corporations, day care providers, and HMOs. All of these entities are subject to a variety of state laws and regulations which affect the cost of their goods or services. As each of these entities is regulated somewhat differently in each state, costs will necessarily vary.[17] Thus, plan costs vary because of differences in many kinds of state regulation which may have no connection to plans other than to affect plans' costs.

The only way to free plans from "state-created" variations in costs would be to preempt all state regulation

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[17] As the *amici* make clear, even uniform hospital rate regulation can and does vary from state to state, resulting in varying costs. (IFEBP Br. 12-13).

which has an impact on cost in any benefit area. Indeed, the HMOs and some *amici* argue that ERISA was designed to preserve a free marketplace for benefit delivery systems. (HMO Br. 14-15; IFEBP Br. 3-5). In this world view, all state regulation of HMOs, commercial insurers, and Blue Cross which increases their costs "relates to" plans.

There is nothing in ERISA's language, structure, or legislative history that supports the view that Congress intended to guarantee ERISA plans a free marketplace in which to operate.[18] Moreover, this "free marketplace" theory is contrary to *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. at 741, where the Court noted that laws which regulate only an insurer or how it sells insurance do not "relate to" plans. Yet, those laws have an economic impact on insurer premiums. The Court and Congress clearly did not envision that commercial insurers or HMOs would operate in a marketplace free from state regulation.[19]

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[18] Indeed, a comparison of ERISA legislative history and the legislative history of the Airline Deregulation Act, which was designed to guarantee airlines a free marketplace in which to set rates, demonstrates that when Congress intends to guarantee a free marketplace, it says just that. *Morales v. Trans World Airlines, Inc.*, 112 S.Ct. at 2034.

[19] New York relies upon and adopts the arguments contained in the Reply Brief of the New York Conference of Blue Cross and Blue Shield Plans and Empire Blue Cross and Blue Shield as to the application of the "insurance savings" clause. However, on the issue of whether the "deemer" clause is implicated in this case, New York adheres to its position that it is not implicated because the district court enjoined enforcement of the assessments, which are imposed depending upon the payor of the hospital bill, against the commercial insurers and HMOs only. They are the only plaintiffs in this case who are payors of hospital bills. The deemer clause is not implicated in a situation where a self-insured group itself does not pay hospital bills. No appeal from the district court's judgment was filed on behalf of the self-insured funds whose bills are paid by commercial insurers. In any case, neither the district court

CONCLUSION

For the reasons set forth herein and in New York's main brief, the Court should reverse the judgment below.

Respectfully submitted,

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nor the Second Circuit ruled on the issue and, should the Court determine that the "deemer" clause issue is presented, the issue should be remanded to the Second Circuit.